The worst of times

MEDICO LEGAL RISKS OF THE GLOBAL RECESSION

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Welcome

Dr Stephanie Bown – Editor-in-chief
MPS Director of Policy, Communications and Marketing

Wherever you are in the world, it is likely that you are working in an increasingly challenging environment. Financial constraints in your workplace and changes to how healthcare is delivered, and by whom, are complex issues affecting many of today’s doctors.

Globally the population is living longer and presenting with multiple comorbidities that demand increasingly complex interventions. Patient expectations are growing – rightly patients expect high quality, safe care, delivered in a respectful, clearly communicated manner – but there has been a change in the doctor–patient relationship and this is something MPS has written about extensively. The patient is now a consumer and the health service has had to adapt accordingly.

These higher expectations mean that patients are more likely to complain about their care. This is something we have been seeing in numerous reports of growing numbers of complaints against doctors; there is no other evidence that the profession’s standards are declining. I have personally heard concerns from our members that the gap between expectations and deliverables is widening, and that they are facing pressures to do more with less.

It is in times of great stress that your professional qualities come to the fore. Your sense of personal responsibility, pride in the care you deliver to patients, and your aspiration towards improvement are decisive attributes that can make all the difference when under pressure. In such moments your professionalism has never been more important.

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MPS was delighted to welcome more than 250 delegates to our International Conference 2012, Quality and Safety in Healthcare: Making a Difference.

Throughout the conference, delegates heard from leading international experts about the importance of listening to patient feedback to improve quality, the need to be transparent and professional when things go wrong, and the cost, both to the doctor–patient relationship and to the doctor’s claims experience, in failing to do so.

I have been encouraged by the feedback from the conference so far – 100% of delegates who completed the post-conference evaluation form said that the programme of speakers met their expectations and they would recommend the conference to a colleague.

The real measure of the conference’s success, however, will be the extent to which delegates take home the key learning points about improving quality and patient safety – and put them into practice.

Ninety per cent of delegates agreed that they were likely to change something in their practice as a result of attending the conference. One delegate said: “We need to challenge the culture of resistance to openness”; another: “I have a much more positive attitude towards aspects of appraisal because I see the evidence behind it now. I feel confirmed and remotivated in what I do.”

I would be very interested to hear your thoughts on what we can do differently in our organisations to improve quality and safety in healthcare. If you have suggestions you would like to share, please do get in touch.

Dr Priya Singh shares her personal experiences of MPS’s international conference

MPS Medical Director Dr Priya Singh shares her personal experiences of MPS’s international conference

Making medicine safer

Healthcare in the 21st century has become highly effective, yet improvements in safety have lagged behind. MPS’s International Conference 2012 – Quality and Safety in Healthcare: Making a Difference moved the focus from making medicine better to making it safer.

By Sarah Whitehouse

Part of making medicine safer is listening to a patient’s experience. Patients are now very active consumers of healthcare, not just passive recipients. Described by conference speaker Dr Neil Bacon, founder of Doctors.net and iwantgreatcare.org, as “the smoke detector of patient safety”, patient experience captures both excellence and the potential for improvement.

As well as patient experience, MPS’s conference – held on 15-16 November 2012, at Church House Conference Centre, Westminster, London – addressed quality, safety culture, cost and professionalism. In partnership with the Canadian Medical Protective Association (CMPA) and MDA National, and key supporters CRICO and PIAA, MPS’s conference welcomed more than 250 international delegates from around the world, including Argentina, Australia, Canada, the USA, the Caribbean and Bermuda, Uruguay, Norway and Ireland, as well as the UK.

Dr Gerald Hickson, Assistant Vice Chancellor for Health Affairs, Vanderbilt University Medical Centre, and Director of Centre for Patient and Professional Advocacy, delivered the first keynote address on delivering quality and trust.

Quality, he said, is about making medicine kinder and safer. Each doctor has a duty to address faulty systems;
To achieve a culture of safety, we first need to talk to each other. Quality is also about promoting reliability – doctors need to know they will be supported by their organisation if they raise any concerns. Similarly, organisations need to tackle unreasonable variations in the performance of healthcare professionals that threaten safety and quality.

Quality, however, means different things to different people. The pursuit of quality in challenging circumstances has one main goal for Dr Devi Prasad Shetty, Chairman, Narayana Hrudayalaya Group of Hospitals – to dissociate affluence from healthcare. Quality is being able to reduce the costs associated with cardiac surgery, by putting a price tag on human life out of necessity. Delivering cardiac surgery for $800 involves streamlining processes, reducing costs, and involving families as primary care providers.

Typically, it takes a catalyst for new aims to be set, or behaviours to alter. If something goes wrong, writing a policy to improve patient safety is the default mechanism, said keynote speaker Dr Carol Haraden, Vice President at the Institute for Healthcare Improvement (IHI). Yet often, there is no well-developed execution strategy – and so excellent ideas and aims to improve patient safety are lost in documentation. Most healthcare organisations have at least 250 guidelines; yet typically, healthcare professionals only put five into practice. To achieve a culture of safety, we first need a culture of improvement.

The shift needs to come from the top. In every healthcare organisation, there needs to be a board level commitment in everything to do with quality, stressed Professor Martin Elliott, Professor of Paediatric Cardiothoracic Surgery at Great Ormond Street Hospital. Talking about teamwork, leadership and professionalism, he said that leaders need to help define the goals of their organisations, set and maintain standards, and act as role models. Force won’t work: the best leaders never bully, but lead by example.

Forecasting medicolegal risk would allow medicolegal institutions (eg, liability insurers, medical boards, hospital risk management departments) to become more proactive in quality and safety improvement efforts, argued Professor David Studdert, Professor and ARC Laureate Fellow at the University of Melbourne. His study is using a unique national dataset on patient complaints against Australian doctors to develop new methods and tools for predicting a clinician’s risk of a further complaint. Over a ten-year period, 18,900 complaints were received about 11,000 doctors in Australia. The research looked at practitioners’ sex, age, practice location and specialty. For all practitioners, standards of clinical care and communication were the main issues. The more complaints a doctor received, the more they were at risk of further complaints. Prof Studdert explained how the PRONE score (PRobability Of New Events) predicts doctors’ medicolegal risk, which could be used as a simple prediction tool for targeting interventions and reducing clinical negligence costs.

Tony Mason, former Chief Executive of MPS, explored the rise in negligence costs in a global context. For some doctors and hospitals, they have already proved to be unsustainable; in the UK, clinical negligence costs are the highest anywhere in the world, except the United States. The Panel Discussion provoked a lively debate about potential ways forward to address this unsustainable rise.

But the fallout from an adverse event is often not about the money, argued Dr Lucian Leape, Adjunct Professor of Health Policy at Harvard School of Public Health, in his keynote address on disclosure and apology. It is about communicating effectively when things go wrong. A serious preventable injury is devastating for the patient – they are doubly wounded. Not only do they suffer a physical wound (the adverse event), they also suffer an emotional wound, the betrayal and loss of trust in the healthcare professional. A serious preventable injury is a medical emergency. If a doctor does not act quickly, things become much worse. The necessary treatment is open, honest and full communication.

In this medical emergency, there is a second victim, the caregiver. Shame, guilt and fear can take over if the situation is ignored. Apologising or admitting something has gone wrong can be difficult, yet Dr Leape suggests it is essential for the caregiver to heal.

Dr Stephanie Bown agreed, outlining MPS’s belief in the necessity of a culture of openness. Legislation cannot work: it only serves to encourage fearful behaviour.

Mistakes do occur. Quality, however, is never an accident: it is always the result of high intentions, said Dr Jason Leitch, Clinical Director at The Quality Unit, Scottish Government, in his keynote address on safety and outcomes. Safer care can only be delivered by frontline professionals doing common things uncommonly well.

To achieve a culture of safety, we need a culture of improvement. John Tiernan, Director of MPS Educational Services, closed the two-day conference with a question: “Delegates from around the world have come to the conference and will leave with great ideas. What will you do with the information you have learnt?”

Visit the MPS website to read the event summary report which features links to videos, podcasts and speaker presentations.
Making methotrexate safer

With a disproportionate number of adverse incidents relating to methotrexate treatment in Ireland, more must be done to eradicate error. Dr Diarmuid Quinlan and Dr Paul Ryan describe why a collective approach is the best way.

In Ireland there has been an unenviable reputation. We have four times more adverse incidents with patients taking methotrexate than in the UK.1 Perhaps Irish people are uniquely susceptible to the side-effects of methotrexate; much more likely is that something is dangerously amiss with our patient safety systems and culture.

Errors can, and do, arise in prescribing, dispensing, administration and monitoring. We need a shared solution to this patient safety issue: patient empowerment is crucial, as patient safety is everyone’s responsibility. The consultants initiating methotrexate, the GPs writing the prescriptions, the pharmacists dispensing; we must sing from the same hymn sheet. We need to promote and ensure safe use of methotrexate at each and every patient contact.

Errors in methotrexate can and do arise with frightening regularity. There are clear roles and responsibilities for everyone involved.

Background

In excess of 11,000 people in Ireland take methotrexate.2 That’s a lot of methotrexate prescribing and dispensing. Some 80% of patients take methotrexate for rheumatological disease, whereas most of the remainder are dermatological indications.3 Is there a commensurate monitoring and safety system in place? The cold statistics suggest we are failing our patients in this regard. Is this a case of familiarity breeding contempt?

We know that monitoring of lithium is seriously deficient in Ireland, with just one third of patients taking lithium appropriately monitored.2 Is this a symptom of a deeper malaise, as yet undocumented, pertaining to other potentially toxic medications – warfarin, “the biologics”, combined oral contraception, NSAIDs to name a few.

NICE guidelines issued in September 2012 outline the responsibilities of doctors prescribing methotrexate.3 The simplicity of these recommendations belies their importance. Ignore them at your (patients’) peril.

Methotrexate is simply one potentially toxic medicine. Many patients experience immunosuppression with chemotherapy. Still more commence novel immune suppressing medications. NICE published a clinical guideline in September 2012, addressing neutropenia in patients taking immune suppressing medicines.4 The clinical difficulty is compounded if these patients are simultaneously taking oral corticosteroids, when signs and symptoms of sepsis may be few or absent. The median onset of methotrexate–induced toxicity is 17 months:5 just when you thought it was safe...

Common errors

Errors in methotrexate can and do arise with frightening regularity. There are clear roles and responsibilities for everyone involved. Almost 40% of Irish patients take 10mg tablets, compared to just 8% in the UK.6 Many of these patients take both 2.5mg and 10mg tablets.7 If you wanted to design a safe patient journey you wouldn’t start here...

However, pharmacists are addressing the safety issues around methotrexate. My local pharmacy stocks methotrexate 2.5mg tablets only. Methotrexate is locked in the safe, to help maintain awareness of the potential toxicity and the need for great caution in dispensing methotrexate; we physicians have a lot to learn from our proactive pharmacy colleagues.

In Ireland an average of two patients taking methotrexate every year.1 These small children take an average dose of 17.5mg. That’s a lot of methotrexate for a small child! Failure to discontinue methotrexate is a common cause of methotrexate toxicity, especially in unwell patients admitted to hospital.1

Fixing the problem

An audit of methotrexate monitoring in my practice in 2008 showed lots of scope for improvement. We are currently repeating this audit but on a much more ambitious scale.

We have engaged with each of the groups involved in methotrexate, and written to our local rheumatology, dermatology and other consultants to highlight the systemic failings in safe use of methotrexate. Our local pharmacists have engaged enthusiastically:

- The 10mg tablets are not stocked; patients are dispensed 2.5mg tablets regardless of the dose.
- Pharmacists also encourage patients to attend for regular blood testing.
- Pharmacists remind patients of the importance of taking methotrexate once weekly, on a specific day of the week.
- They ensure folic acid is dispensed and taken appropriately.

Crucially, they now inform patients of the signs and symptoms of methotrexate toxicity and what action to take if such signs/symptoms arise. The law is frighteningly simple. Responsibility rests with the doctor who signs the prescription. Your signature...you’re responsible. No wiggle room! So what can you do?

Informed consent

Start with informed consent, and informed means informed. Patient empowerment is vital to ensure a safe methotrexate journey. Ensure the patient is aware of the risks and benefits of methotrexate. Have you documented this? Did you have this conversation once, many moons ago, or is it...
Start with informed consent, and informed means informed. Patient empowerment is vital to ensure a safe methotrexate journey. Ensure the patient is aware of the risks and benefits of methotrexate.

a regular discussion? What about a footnote to the methotrexate script: this could advise of the signs and symptoms of methotrexate toxicity, and the need to act urgently should these arise. A computer-generated template makes this fast and easy. Recommend that 2.5mg tablets only are to be dispensed, and how many to take; also, specify the day of the week.

Regular blood tests
Link patient blood testing to prescribing. This ensures a robust system to ensure regular monitoring. No test, no script, no exceptions. The BNF has recommendations about the recommended blood testing intervals.6

Information
We have developed a simple patient alert leaflet. We print it on bright yellow A4 paper for instant recognition. It folds nicely to a credit card size for ease of storage and retrieval by the patient.

Extra vaccinations
Patients taking immunosuppressants are immunocompromised! Consider the uptake of flu and pneumococcal vaccines. The next edition of the national immunisation guidelines will specifically address the area of immunosuppressed patients.

Assess alcohol intake
Methotrexate and alcohol are both effective hepatotoxins. Patient education, including assessment of alcohol intake, is part of the recommended clinical assessment for methotrexate toxicity.7 Have you had that discussion yet?

We are all responsible
Methotrexate toxicity represents a real and ongoing threat to our patients, and we all have a role in addressing this. A shared responsibility exists to address our responsibilities to patients and patient empowerment is central to the safe use of methotrexate. Once you start down this road you might subsequently consider lithium, warfarin, DMARDs, to name a few.

Start today and build a safe methotrexate culture in your practice. It is good for patients and good for doctors...a win-win situation.

Dr Diarmuid Quinlan is a GP and Dr Paul Ryan is an intern and qualified pharmacist, both based in Cork.

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Behind bars: providing care in custody

Conducting medical assessments of patients in custody is an area of medicine that is fraught with difficulties, yet is too often overlooked. Rachel Seddon looks at the potential risks of dealing with detainees.

When doctors receive a call from the Gardaí asking for a medical assessment or treatment of a detainee, many will feel their heart sink. Whilst in some areas this can be a fairly common request, learning how to assess patients in custody does not make up any part of the formal medical training scheme, meaning doctors can feel nervous about carrying one out. Equally, with no dedicated forensic physicians in Ireland and no official guidance for doctors, it’s not surprising that many don’t know who to turn to for help when dealing with these tricky situations.

Because there are no official forensic physicians, any doctor may be called upon to conduct a medical assessment of someone who has been detained in custody – either at the request of the patient or the Gardaí. These patients will often be unlike those on a typical GP’s practice list, and will have unique problems that will need a doctor’s expertise to assess. Even detainees with common medical problems will often be more challenging to deal with due to the lack of available equipment or supplies needed to treat them.

Guidance on prisoners’ rights says doctors should treat detainees “with the same dignity and respect as patients would receive outside” at all times, offering them the same medical treatment as they would to other patients whilst being mindful of the unique needs detainees might have.

Before you start

Upon arriving at a Garda station, anything could be waiting for you: violent detainees, a detainee who has been assaulted, people with signs of substance abuse; the list goes on. The Garda Member in Charge will need you to assess the patient to determine their current medical state and also their fitness to be detained and interviewed.

The first thing a doctor must do is ensure the patient understands what is happening and to gain their consent before proceeding with a medical assessment. Part of the process of obtaining consent has to include building up trust between yourself and the patient, and for this, you will need to communicate openly with the patient.

One of the main problems in custody settings is the lack of resources available to allow doctors to carry out an appropriate assessment. Dr George Fernie, senior medicolegal adviser at MPS, says: “It is rare to find designated medical examination rooms in Garda stations; this can make it very difficult to conduct a confidential discussion with, and examination of, any patient being detained in custody.”

As soon as possible after arriving at the station, speak to the Member in Charge to establish whether there is somewhere private that you and the patient can go to talk confidentially.

Of sound mind?

When a patient has been detained emotions may be running high, making it difficult to assess their mental capacity. Doctors may find detainees behave erratically, are unusually loud or aggressive; others may refuse to say anything at all.

With the absence of any

During the consultation, introduce yourself and explain why you have been called. Reassure them that you owe them a duty of care and are not there to cast judgments on them. Outline the nature of the assessment or treatment you plan to provide, and give them an opportunity to ask you any questions. You should explain the differences between your forensic and therapeutic roles, and make sure the patient knows

As soon as possible after arriving at the station, speak to the Member in Charge to establish whether there is somewhere private that you and the patient can go to talk confidentially.
Remember, capacity can fluctuate in some patients at different times of the day, particularly if the patient has taken certain medications.

statute-based legislation relating to assessing mental capacity, doctors have to rely on their own clinical judgment. If you have never come into contact with the patient before, you will not be in a position to determine what constitutes normal behaviour for them. In these cases, use skills developed during your medical training to decide if a detainee has the capacity to consent to a medical assessment or to determine if they are fit to be interviewed.

The standard test of capacity is in three parts, all of which have to be fulfilled for a patient to be deemed competent:

1. Can the patient comprehend and retain treatment information for long enough to make a decision?
2. Does the patient believe that information?
3. Can the patient weigh that information, balancing risks and needs, to arrive at a choice?

You also need to ensure the patient can communicate their decision to you successfully. Remember, capacity can fluctuate in some patients at different times of the day, particularly if the patient has taken certain medications. If you have doubts over the detainee’s capacity, any consent they have given could be deemed invalid. It could also cast uncertainty over other information they have given, such as their past medical history. Assessing capacity is the cornerstone of your entire visit. Doctors who fail to spend enough time establishing capacity may later find they had based clinical decisions on information that was incorrect. Always keep detailed contemporaneous notes on the discussions you had with the patient and record how you arrived at your decision.

Don’t give in to pressure

Some detainees, particularly those who have a history of drug abuse or opiate dependency, may deliberately provide misleading information about their medical history to get you to prescribe medication. Because many detainees are brought in outside normal working hours, it will not always be possible to get a copy of their medical records – or to contact someone who can verify the information – at the time of assessment.

“Don’t prescribe until you are cast-iron sure,” says Dr Andrew Wilkinson from the department of Forensic and Legal Medicine at UCD. “If necessary, treat withdrawal as and when symptoms occur, but do not prescribe medications such as methadone unless you are certain about the patient’s course of treatment.” Detainees may be well-versed in convincing a visiting doctor that they can be trusted, but always remember that powerful drug addictions can lead to highly manipulative behaviour; always err on the side of caution and wait until you have seen their medical records or spoken to their GP if you are unsure.

Training is key

Although specific training on assessing patients in a custody setting is rare, all doctors should make an effort to familiarise themselves with the potential risks, in case they are next to be called up by the Gardaí. Doctors shouldn’t feel pressured to carry out impairment testing if you have not been trained or don’t feel adequately equipped.

If you are asked to assess patients in custody, talk to experienced colleagues, consider completing a course or attending CPD sessions and read any material you can get hold of, such as FFLM publications, which discuss the main risks and pitfalls to avoid; or call MPS for advice.

Above all, don’t forget that the key medicolegal concepts – assessing capacity, obtaining consent, maintaining confidentiality, keeping detailed records, safe prescribing and undertaking a comprehensive medical history and examination – apply in these difficult situations just as much as they do in the practice consulting room.

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The worst of times

Medicolegal implications of the recession

Unemployment reduces wellbeing. Recession raises the demands on healthcare systems and makes it harder to pay for them. Doctors worldwide are having to adapt and change to cope with these additional pressures, says Sarah Whitehouse.

The impact of the recession on healthcare reads like a gloomy checklist of the multi-symptom patient: increased stress, depression and anxiety; an increase in alcohol consumption; an increase in stomach and digestive problems; and an increase in obesity. A study by the Insight Research Group of 300 UK GPs reported that 17% noted an increase in requests for terminations of pregnancy specifically because of financial concerns. Skin complaints are even on the rise. Research by the British Skin Foundation suggests that nine out of ten dermatologists have noticed a marked rise in eczema, psoriasis and other skin conditions triggered by stress. Most dispiringly, international research suggests that for every 1% increase in the unemployment rate, there is a 0.78% increase in the rate of suicide.

The impact on doctors
But what does all this mean for doctors? Primary healthcare, often the first point of contact, has been hard hit. The Insight Research Group also reported that 77% of UK GPs feel there has been an increase in new cases of mental health conditions in the last four years directly linked to the economic climate.

Secondary care, too, has been affected. In the UK, almost 6,400 people were admitted to hospital with stress between the period January – May 2012, 47% up on 2007-8, when the economic crisis hit. In the Caribbean, public healthcare systems are being stretched as the recession forces more patients to move away from private care. Dr Nancy Boodhoo, MPS Head of Operations, Caribbean and Bermuda, says that this is a particular issue for obstetric care because of spiralling costs.

Maintaining standards
One of the biggest challenges facing doctors is balancing an increase in patients’ needs with maintaining high standards of care. Remember your professional obligation to take a thorough medical history and an examination if necessary – and document both. Record keeping standards can easily slip if a consultation over-runs, but it is important to stop and make notes before rushing to see the next patient.

Be aware too of “by the way” comments, where symptoms might be mentioned in passing as the patient is on their way out of the door. These symptoms can often be the real reason behind an appointment, so make sure you...
If you find that you are so overstretched that the situation is in danger of putting patient safety at risk, or your health begins to suffer, you should raise your concerns within the appropriate channels.

Act within your competence
MPS has received a number of calls from hospital doctors who feel uncomfortable at being asked to provide cover for an area they do not normally specialise in due to staff shortages. For example in psychiatry, adult psychiatrists are often asked to step in and cover children and adolescent psychiatric care.

Dr Ming-Keng Teoh, MPS Head of Medical Services (Asia) explains that some medical private practitioners seek to maintain their income (as patients turn to the public sector) by choosing to take on a wider range of treatments (e.g., GPs undertaking cosmetic procedures), as well as patients (paediatricians seeing adult patients, obstetrics and gynaecology consultants examining patients with breast lumps). Doctors who choose to do this are practising in areas beyond their expertise and may fail to refer appropriately. You have a professional obligation to work within your competence – and should raise your concerns with a senior colleague or employer if you are asked to perform a procedure that you are unsure of.

Managing expectations
Speaking this year at an MPS conference for newly-qualified consultants, MPS Head of Medical Services Dr Nick Clements said: “There has to be a balance between the patient’s interests, the need to control budgets and where the doctor’s duty lies in these difficult circumstances. Often, the buck seems to stop with you, the doctor. If a patient cannot get the treatment they want, or the drugs they want, they will blame the doctor who is saying no. Doctors need to have the right communication skills to handle these situations carefully and manage patient expectations.”

Some patients see making a claim as a financial opportunity in these tough times. In Ireland, the average size of claims against doctors has increased by 37% between 2007 and 2011. Dr George Fernie, MPS Senior Medicolegal Adviser, says: “There has always been tension in Ireland with the public and private mix, but it’s been magnified with the recession. We have seen a case where a doctor reasonably asked a patient on long-term prescription to come in for a review, but the patient felt that this was financially motivated and lodged a complaint.” You should always explain your reasons for calling a patient in for a review, clearly explaining the health benefits and the need for follow-up.

Delaying a visit to the doctor
In some countries, the economic downturn means that patients are accessing healthcare less frequently. In Ireland, those without Medical Cards are increasingly putting off making an appointment, which can have an impact on early diagnosis and the treatment of long-term conditions. Requests for telephone consultations are on the rise, and with them the risks of potential missed diagnosis. Failure to diagnose is a common cause of a complaint or a claim, so it is important to have a low threshold to invite the patient in for a review.

Dr Brian Charles, Emergency Physician and MPS Consultant, based in Barbados, says: “A particularly worrying trend has been patients ‘waiting to get better’ before seeking medical care, particularly those with medical insurance who have to pay upfront and wait for reimbursement later. This has resulted in patients presenting to primary care physicians later in the course of their illness, with more complications.”

Despite the impact of the recession being less marked in Hong Kong, Malaysia and Singapore, which generally have more private practices and less welfare spending, Dr Teoh says: “Recession has had an impact in the public sector, reducing the number of consultations,
as patients are less likely to take time off work to seek healthcare. They cannot afford the time, rather than they cannot afford the cost of healthcare itself. A reduction in patient numbers has also led to many doctors in private practice resorting to longer opening hours, more practice promotion activities and more turf battles between doctors. The respective Medical Councils do not permit doctors to promote their practice or advertise or canvass for patients, and so doctors may find themselves in murky medicolegal waters if they do try to seek new patients in this way. They are advised to consult and seek legal advice if unsure.

Where does a doctor’s duty lie?
The conflict between a doctor’s duty to their patient, and the patient’s ability to pay, can be all too real. An MPS GP, based in Ireland, describes a case where a patient with depression wanted to wait to pick up his anti-depressant prescription until he was paid. The GP was concerned – the patient had severe depression and was at risk if he did not take his medication. The GP spoke to the pharmacist and agreed to postpone the fees for a few days until the patient was able to pay.

Dr Charles says that in the Caribbean: “Private practitioners are frequently faced with the ill patient who cannot pay (or at least, cannot pay at the time of the encounter), and they too must be compassionate and not put that patient at harm by denying appropriate care. All must be done to ensure that these patients are stabilised and properly referred onwards for the complete care they need.”

Yet doctors must retain a degree of realism. They cannot be responsible for putting right the social and financial woes of all their patients, as well as their ill health. To do otherwise may well result in burnout for the already overstretched doctor. In the UK, the GMC, in Good Medical Practice, states that good doctors “make the care of their patients their first concern”, but “must make good use of the resources available”. Unfortunately, these are not finite.

Conclusion
One small positive can be gleaned from the UK GP research into the effects of the recession on healthcare: 38% of GPs believe that patients who smoke are giving up or cutting down to save money.

However, the pressure cooker of reduced health and increased demand for healthcare continues to affect most doctors. Dr Clements sums up: “Do the best you can with the resources available. Make sure that any resource-related decisions are fair and based on clinical need and remember to be open and honest with patients about the constraints.”

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On the case

Dr George Fernie, Senior Medicolegal Adviser, introduces this issue’s round-up of case reports.

When treating patients who attend the surgery frequently, especially within a short space of time, it can be all too easy to be blinded by a familiar diagnosis based on pattern recognition, particularly if it is a commonplace, and seemingly innocuous, condition. The safest approach when treating these patients is to go back to basics: document a thorough history and be prepared to re-examine the patient if their symptoms change.

Back pain is one of the most common complaints seen in general practice. Doctors may easily discount it, but it is important to remember that a small proportion of such cases mean serious or life-threatening pathologies. In “Back with back pain” on page 16, Mrs S’s recurrent urine infections, in association with back pain, were found to be co-existing with non-Hodgkins lymphoma. Despite a claim being made against Dr F for failing to refer Mrs S earlier, Dr F’s good documentation of the history and his examinations meant that this was discontinued. Experts found that there was a careful, well-documented assessment of Mrs S on every occasion, which showed that at no time was an emergency referral warranted.

In direct contrast, a claim against Dr W for a missed SAH in “Take me seriously” (page 14) had to be settled for a high sum. There was no evidence in the records that Dr W had taken any history or performed an examination. As a result, Mrs T’s fatal SAH was missed. One consultation was recorded simply as “Migraine. Prescribed some painkillers.” Despite Mrs T returning to the surgery several times with recurrent headaches, and later with pain shooting down the back of her neck, the potentially life-threatening causes of her recurrent headaches were not considered.

Similarly, in “Where the heart is” on page 21, Mr R’s high blood pressure was attributed to anxiety before more sinister pathologies were excluded. His risk factors for cardiopulmonary disease should have been considered when taking the history, examining and arranging follow up tests.

The learning points from all these cases is that potentially serious pathologies should never be discounted before a proper assessment has been made and a detailed history taken. Comprehensive records should be made of both.

CASE REPORT INDEX

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Since precise settlement figures can be affected by issues that are not directly relevant to the learning points of the case (such as the claimant’s job or the number of children they have) this figure can sometimes be misleading. For case reports in Casebook, we simply give a broad indication of the settlement figure, based on the following scale:

- **High** €1,500,000+
- **Substantial** €150,000+
- **Moderate** €15,000+
- **Low** €1,500+
- **Negligible** < €1,500

Casebook publishes medicolegal reports as an educational aid to MPS members and to act as a risk management tool. The reports are based on issues arising in MPS cases from around the world. Unless otherwise stated, facts have been altered to preserve confidentiality.

Although case reports are based on real cases from the MPS caseload, they have been anonymised and amended. As a result, the narrative is not wholly factual. What is most important is the learning points that can be taken away from each report, rather than the clinical detail itself.

When read with this approach in mind, the case reports section provides an invaluable resource for medicolegal learning and risk management.
Forty-year-old hairdresser and mother-of-three Mrs T had long-term problems with neck pains and migraines. She had seen her own GP Dr W, and many of the partners in the practice, several times over the years with the same complaint. Her symptoms had been largely attributed to muscular spasms due to her job. One day, Mrs T attended Dr W’s surgery with a headache she felt was much worse than usual. She had also experienced several episodes of vomiting that morning. Although the history of migraine was well-established, the symptoms she presented with “felt different to her usual migraine”. She described pain shooting down the back of her neck, which had never happened before. Dr W documented the consultation with one line in the notes, stating: “Migraine. Prescribed some painkillers.” There was no evidence in the records about any history taken or examination performed. Over the next three weeks, Mrs T attended four more times with ongoing symptoms, seeing different partners each time. She asked for a private referral to a chiropractor as she thought she had “wry neck” and simple analgesia was providing no relief. Frustrated with the ongoing headache, she even attended the Emergency Department once but no investigations were carried out, based on the chronicity of her symptoms and her long history of migraines. Four weeks from the onset of this latest, severe headache, Mrs T had a seizure followed by a fatal cardiorespiratory arrest. The postmortem showed that she had suffered a subarachnoid haemorrhage.

Mrs T’s family made claims against all the doctors involved in her care, including hospital doctors, and the case was settled for a high sum.

**LEARNING POINTS**

- Those who reattend frequently with the same complaint might be seriously ill. A safe approach is to go back to basics, by documenting a thorough history and examination of the problem.
- Listening to what the patients tell you remains one of the best medical tools. A patient with chronic migraine who describes her headache as different to previous ones deserves careful attention. Try not to allow a consultation to be prejudiced by what has happened before and do not let the patient’s self-diagnosis prevent you from keeping an open mind as to the cause of their symptoms.
- NICE have similar guidance: Headaches: Diagnosis and management of headaches in young people and adults http://publications.nice.org.uk/headaches-cg150
- Headache is a common symptom and missed SAH is a frequent source of litigation. Casebook has featured similar presentations of SAH in the past, which may be of interest:
  - MPS Casebook, Not just another headache, 17 (3) (2009)
  - MPS Casebook, Sudden first and worst, 16 (1) (2008)
  - MPS Casebook, Sudden, first and worst again, 16 (2) (2008)
- If aneurysmal SAH is treated urgently, complications can be reduced. Kowalski et al noted that misdiagnosis of SAH in patients who initially present in good condition is associated with an increased mortality and morbidity. They suggest a low threshold for CT scanning and highlight the importance of immediate aneurysm repair – stating that rebleeding occurs in 26%-73% of patients within days or weeks if left untreated. Kowalski R et al, Initial misdiagnosis and outcome after subarachnoid haemorrhage, JAMA 291(7):866-869 (2004) http://jama.jamanetwork.com/article.aspx?articleid=198199
- Remember the importance of lumbar puncture – CT scans may often come back negative.
- Ensure that you keep accurate records, as when a claim is made, evidence is collected from a number of different sources and records may be cross-referenced. For example, hospital records on admission may contain a history that is very relevant in a claim relating to a GP’s earlier actions.
Mrs B was a 35-year-old housewife with two children. She was well-known at her GP surgery since childhood and had needed support with a troubled past. She had suffered abuse as a child and domestic violence in her first marriage. She attended the surgery very frequently with anxiety issues and lots of minor ailments. She would have a list of things that she wanted to discuss each time she attended and consultations would frequently take a long time.

Some years ago, Mrs B had been referred to the breast clinic and was diagnosed with fibrocystic disease. Mrs B mentioned several times on her way out of the doctor’s room of having sore and lumpy breasts. Several of the GPs she had seen had documented this as part of her lengthy consultations and she was examined several times. This, however, always seemed to be part of a "by-the-way" mention rather than a full and detailed examination. Mrs B felt anxious about her breasts and continued to report this when she saw her GP about other things.

Dr T knew Mrs B well and found her to be a challenging patient. He always seemed to be part of a “by-the-way” mention rather than a full and detailed examination. Mrs B felt anxious about her breasts and continued to report this when she saw her GP about other things. Dr T knew Mrs B well and found her to be a challenging patient. He struggled to be able to separate her physical and psychological issues, which were often intertwined. Mrs B always seemed very emotional about her personal problems and Dr T knew he would always run late after he had seen her. He found her increasing breast discomfort was difficult to assess. Dr T had wanted to give fuller attention to Mrs B’s breast symptoms and had asked her to return on another day for a new assessment, but she had failed to attend. Dr T’s partners also saw Mrs B many times and multiple symptoms and issues. A breast examination had been documented several times by different GPs and always mentioned lumpy breast tissue. Fibrocystic breast disease was mentioned on each occasion. After 12 months she was eventually referred to breast clinic with her persistent symptoms. She was diagnosed with breast cancer. Unfortunately, her disease was quite advanced and she needed a mastectomy and chemotherapy.

Mrs B made a claim against the doctors at her surgery for the delayed diagnosis. The case was settled for a moderate sum.

LEARNING POINTS

- Fibrocystic breast disease is a diagnosis of exclusion. If symptoms persist the diagnosis needs to be challenged on a regular basis. The initial diagnosis could have been wrong or it may have evolved into something else.
- Continuity of care is important, especially in reviewing the nature of a breast lump over time. This can be difficult in busy surgeries with many GPs but it is good practice to ensure that it is the same doctor each time in order to make the comparison objective. As more healthcare professionals are involved in a patient’s care, comprehensive notes and good communication are important.
- NICE has published guidance on Improving Outcomes in Breast Cancer (28 August 2002). It has a useful section on managing breast lumps which GPs should be familiar with. The document makes several recommendations, some of which are outlined below:
  1. All patients with possible or suspected breast cancer should be referred to a breast clinic without delay.
  2. Urgent referral (within two weeks) should be arranged for:
     - Patients aged 30 or over with a discrete lump in the breast
     - Patients with breast signs or symptoms which are highly suggestive of cancer. These include ulceration, skin nodules, skin distortion, nipple eczema, recent nipple retraction or distortion (<3 months) or unilateral nipple discharge which stains clothes.
  3. Breast lumps in the following patients or of the following types should be referred but not necessarily urgently:
     - Discrete lump in a younger woman (<30 years)
     - Asymmetrical nodularity that persists at review after menstruation
     - Abscess
     - Persistently refilling or recurrent cyst.

- Beware of “by-the-way” mentions from patients on their way out of the surgery. Sometimes they hide serious pathology. If there is no time for a full assessment, arrange a new, later appointment.
- Challenging patients may require particular care. Patients with complex psychological, social and psychiatric needs can, and often do, have physical problems. There is an interesting article about challenging patients in Casebook (May 2009). It has some insightful case reports and tips on management.
- Patients that don’t attend their appointments raise several issues. Where does the doctor’s responsibility end? What should GPs do about it? It may be useful to have a practice meeting to discuss this and consider developing some practice guidelines about safety netting for did not attend patients.
Mrs S was a 35-year-old shopkeeper with an established history of recurrent UTIs, which had responded well to antibiotics. An ultrasound in the past had confirmed kidney stones. She presented to her GP, Dr F, complaining of back pain for the past six weeks and tingling in her right leg, which was relieved by lying down. Dr F took a full history and examined her back, including a neurological examination. Dr F diagnosed Mrs S as having sciatica, exacerbated by lifting heavy boxes in the shop. Dr F prescribed regular analgesia and advised her about careful lifting and gentle exercises. However, the pain continued to worsen. Dr F saw her again four weeks later and this time was concerned as Mrs S was having difficulty walking. She was referred for physiotherapy.

Whilst waiting for the physiotherapy appointment Dr F saw Mrs S again, this time with symptoms of a urinary tract infection including frequency and urge incontinence. Again a urine sample was sent to the lab and confirmed a urinary tract infection, which was treated successfully with antibiotics. Mrs S’s back pain and right leg sciatica continued to deteriorate to the extent that she could not sit and she returned to the surgery again. Dr F was concerned about the repeated urine infections in association with back pain and the recent onset of incontinence, and informed Mrs S that she felt an ultrasound scan of her urinary tract system would be prudent. A urology referral was made and a CT scan confirmed a renal stone and a retroperitoneal mass. Mrs S had further investigations for the mass and was eventually diagnosed with non-Hodgkin’s lymphoma.

Mrs S was very upset when she was diagnosed, as she felt the back pain had always been due to the mass, and she made a claim against Dr F for failing to refer her earlier. Experts who looked into the case agreed that the management had been appropriate and Dr F had acted like any other reasonable GP would have at the time. The experts also found that although some of the examinations weren’t examples of best practice, they were not below an unacceptable level. At no time was an urgent or emergency referral warranted. The case was discontinued after a detailed letter of response was sent.

Back with back pain

- Back pain is one of the commonest complaints seen in general practice. Doctors may easily disregard back pain but it is important to keep in mind that a small proportion of them mean serious or life-threatening pathologies.
- Taking a good history and examining the patient regularly when they attend with recurrent back pain is important, even if they come with a recurrent complaint. Re-examine if there is any change in symptoms. Good documentation of history and examination is safe practice. This helps other clinicians to understand the history of a complaint better. It can be the basis of a good defence if a case ever becomes a claim.
- When patients attend with different symptoms and illnesses at the same consultation, differential diagnosis can be more complex and therefore greater awareness is necessary.
- Keep up-to-date with guidelines on best practice for back pain. The NICE guidelines for low back pain can be downloaded here: www.nice.org.uk/CG88quickrefguide. This covers management of musculoskeletal back pain but not malignancy, infection, fracture and inflammatory conditions such as ankylosing spondylitis. Remember these alternative differential diagnoses when assessing a person with back pain.
- Failure to diagnose is not inevitably negligent. There was a careful, well-documented assessment of the patient on every occasion.
Mrs H, a 23-year-old professional photographer in her first pregnancy, was pregnant with twins. The pregnancy progressed without any complication, until week 36 when she went into preterm labour. Dr L was the obstetrician on duty. As the first twin was a breech presentation, an emergency caesarean section was performed under spinal anaesthetic and both twins were delivered in good condition.

Soon after the procedure, whilst still in the recovery room, Mrs H began bleeding steadily vaginally and became hypotensive. She was resuscitated with intravenous fluids. Dr L administered oxytocin with little effect, followed by insertion of misoprostol per rectum. He did not follow hospital protocol for postpartum haemorrhage which advised the administration of ergometrine and carboprost if the bleeding continued despite the use of oxytocin. As the bleeding continued, Dr L decided to take Mrs H to theatre for an examination under general anaesthesia to identify the source of bleeding. In the meantime, resuscitation continued with blood products. During laparotomy, the uterus was found to be atonic, but there was no rupture or evidence of any retained products of conception.

Unfortunately, Mrs H's condition deteriorated and she began to develop disseminated intravascular coagulation. Dr L reported this to the patient’s husband, informing him that “there were no options” other than removing the uterus. It was impossible to gain informed consent from the patient as a consequence of her clinical condition at that time. Dr L proceeded to perform a hysterectomy. Mrs H made a satisfactory recovery from her surgery, but made a claim against Dr L for his management.

Experts were critical of Dr L, as he had failed to follow the hospital guidelines on the management of postpartum haemorrhage and secondly by not considering alternative surgical options such as internal iliac artery ligation or ligation of the uterine and ovarian arteries. Furthermore, Dr L had not documented why he had not considered less radical intervention before resorting to a hysterectomy in such a young woman in her first pregnancy.

The case was settled for a moderate sum.

GM

Ignoring the guidelines

Obstetrics Investigations/Record-Keeping

LEARNING POINTS

- Postpartum haemorrhage remains a leading cause of maternal morbidity and mortality.
- As part of good clinical governance, obstetric departments will have guidelines on the management of massive haemorrhage.
- The management of massive obstetric haemorrhage should be included when practising emergency drills on the labour ward, as well as forming part of regular education for all staff that look after pregnant women. This would help ensure staff are familiar with local guidelines.
- It may be justifiable to deviate from local guidelines in an emergency, but it is very important to document any reasons for doing so.
- Women at high risk of postpartum haemorrhage should have a written management plan, including any prophylactic measures that need to be implemented. Multiple pregnancy is a risk factor for postpartum haemorrhage as a result of uterine atony.
- The decision to perform a postpartum hysterectomy can be a difficult one to make as it will have irreversible consequences. It is good practice to discuss the decision with an experienced consultant colleague.
- Women who have suffered a major obstetric complication should be offered the opportunity to discuss the events with a consultant obstetrician and senior midwife and be offered the necessary support.
Mr P, a 49-year-old taxi driver, had recently visited his local Emergency Department (ED) with chest pain. He ended up being transferred to the regional cardiac unit where, according to his brief discharge advice note, he had “emergency coronary bypass surgery (full discharge letter to follow)”. Three days later after getting home he developed aching discomfort in his right lower leg and reattended his local ED, taking the discharge note with him. He was seen by junior doctor Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

The following evening Mr P reattended the ED as he was still getting intermittent pain and was seen by Dr A, a more experienced junior doctor. After examining him Dr A obtained the notes from the previous day’s visit and felt able to reassure Mr P that he simply had not given enough time for the antibiotics to work. Mr P specifically asked about the possibility of deep vein thrombosis, but Dr A advised him that her senior colleague had considered that on his previous visit and felt it was very unlikely. Dr A noted in a statement she wrote for the subsequent investigation that she did not bother her senior on the evening of Mr P’s second visit as “he’d only just gone for a break”. She discharged Mr P with some stronger painkillers.

During the next two days, Mr P rang his GP Dr X on two occasions. Dr X went through his symptoms on the phone and noted that the ED had “excluded a DVT” (he had not received any communication from the ED and had not yet received a full discharge summary from the tertiary unit). He reassured Mr P that he was happy with the assessment in the ED and that he should continue taking the antibiotics and the painkillers prescribed. The following night Mr P, unable to sleep because of the pain, reattended the ED. By now his leg was cold, pale and mottled. Further investigation identified an embolus occluding his femoral artery, which had arisen from the site of coronary angiography he had had performed via the right groin. Despite the best efforts of the vascular surgical team he went on to require an above knee amputation.

Mr P made a claim against all the doctors who had been involved in his care prior to his last ED attendance. The claim was settled for a substantial sum.

J J

No leg to stand on

Mr P, a 49-year-old taxi driver, had recently visited his local Emergency Department (ED) with chest pain. He ended up being transferred to the regional cardiac unit where, according to his brief discharge advice note, he had “emergency coronary bypass surgery (full discharge letter to follow)”. Three days later after getting home he developed aching discomfort in his right lower leg and reattended his local ED, taking the discharge note with him. He was seen by junior doctor Dr B. Dr B examined his lower leg and noted that the wound from his saphenous vein harvest site looked inflamed. He documented that there were no clinical signs of a deep venous thrombosis and discharged Mr P home with a course of oral flucloxacillin.

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Mr P made a claim against all the doctors who had been involved in his care prior to his last ED attendance. The claim was settled for a substantial sum.

LEARNING POINTS

- Examine your patient properly and fully – had the entire leg been assessed the femoral arterial puncture site would have been seen and may have led to earlier diagnosis of arterial problems.
- Earlier and fuller discharge letters might have similarly alerted the doctors involved to the fact that coronary angiography had been carried out.
- Retattending patients can easily be perceived as a nuisance, but should instead prompt consideration of why they are reattending.
- Do not rely on a colleague’s earlier diagnosis – they may have been wrong or things may have developed further, providing clues that they did not benefit from when they assessed the patient.
- You should always seek senior input, even if it is inconvenient.
- Beware of blinkered decision-making. Doctors often use heuristic pattern recognition to make rapid diagnoses, eg, one’s intuition, but this can lead to errors if the wrong pattern is recognised and alternate diagnoses are not considered. Keep an open mind. Do not be afraid to rethink your original diagnosis.
- Pain out of keeping with the clinical findings or diagnosis should always prompt review – and merits more than telephone advice, especially when a patient has undergone major surgery.

REFERENCES

2. Williams S, Tunnel vision, Casebook (May 2011)
Mr C, a 40-year-old carpenter, attended his local Emergency Department (ED) with a severe headache, vomiting, blurred vision and photophobia. These symptoms responded to analgesics and antiemetics. History and examination suggested possible intracranial pathology. The CT scan performed showed no evidence of a subarachnoid haemorrhage but did show a large tumour in the pituitary fossa.

Recently appointed consultant neurosurgeon Mr Y was soon involved in Mr C’s care. He requested immediate ophthalmology assessment and a visual field defect was excluded. Mr Y arranged a pituitary function test but proceeded before the result was available. Mr Y discussed the problem with Mr C and informed him that due to possible pituitary pressure on the optic nerves there was a high risk of blindness, and growth of the tumour might affect the function of the pituitary. Mr C agreed to immediate surgery.

Mr Y had very little experience of pituitary gland surgery. He chose a surgical approach that he felt familiar with, a left-sided fronto-temporal craniotomy, adopting a subfrontal and transsylvian approach to remove the tumour. The procedure was complicated as the tumour was very friable.

Postoperatively Mr C had a dense hemiparesis. A repeat CT scan revealed extensive capsular infarct on the left side of the brain and a lacuna infarct on the right. It took several months for Mr C to recover any independence and he was left with right-sided permanent neurological damage with hemiparesis. Subsequently he was also found to have raised prolactin levels and ACTH and gonadotropin deficiencies requiring hydrocortisone and testosterone. He made a claim against Mr Y.

Expert opinion was critical of Mr Y’s management on various counts. Preoperatively Mr C had normal vision so he was not at immediate risk of blindness as a consequence of pressure on the optic nerve. However as the tumour enlarged he may have been at risk of pituitary infarction (apoplexy), further affecting the hormonal function of the pituitary gland. Cases such as this are usually managed jointly with an endocrinologist who will assess the function of the anterior and posterior pituitary, by appropriate biochemical tests, such as stimulatory hormonal testing, and for posterior pituitary, a prolactin level.

Medical management could delay surgical intervention if the optic nerves were not at risk and the tumour size did not suggest a risk of infarction. The experts were also critical of the surgical approach, which was not in line with usual practice. They agreed that there was no clinical indication for the urgency with which this procedure was undertaken; had an MDT assessment been undertaken he wouldn’t have had surgery. The case had to be settled for a high sum.

**LEARNING POINTS**

- Patience and an awareness of one’s own expertise and knowledge are vital to practise safe surgery. It is rarely appropriate to rush into a procedure, particularly if this means there is a risk of taking an incorrect or risky approach.

- A surgeon may need to take rapid and difficult decisions intraoperatively; however, preoperatively it is important to take appropriate time to review all investigation and treatment options to ensure the best outcome for the patient.

- In medical practice recognising one’s limits (cognisance) and accepting that something may go beyond one’s expertise and training is essential for good medical practice. This might be particularly hard for newly-appointed consultants eager to establish their clinical practice and expertise to their senior colleagues.

- It is important to gather all the facts available to define the clinical situation of the patient before deciding on any management plan. It is here that joint or team working may be appropriate and helpful. In retrospect, in this patient, there were a number of unanswered questions such as the precise nature of the lesion; whether more tests should have been carried out to define the situation; whether the surgery was needed at that time; and whether the patient was at risk of pituitary apoplexy.

- Working as a team provides an extra safety net to medical practice. In areas such as pituitary surgery, it is common practice nowadays to work in conjunction with the endocrinology team, who can give advice on the medical investigations to define the patient’s problem and assist in postoperative hormone replacement as appropriate.
Ms W, a 45-year-old secretary, had poliomyelitis as a child, which left her with a leg length discrepancy, the right leg being several cm shorter than the left. Despite the obvious cosmetic appearance and impaired functional mobility, she had never thought of having any form of treatment. However, one day she watched a programme on TV about surgery to lengthen limbs, so she asked her GP to get her an appointment to see the surgeon involved in the programme, Mr A. Mr A saw Ms W in clinic; soon after she had a date for her surgery. Mr A did not document any counselling of the potentially serious side-effects or the intensive physical therapy that would be required after the operation. All the people in the TV programme had had great results. Mr A did not explain that this was not always the case, nor was the risk that she may be worse off after surgery explored. Mr A only made brief notes at the initial consultation, the operation and follow-up with no documentation about explanation of risks and complications. Unfortunately, the postoperative progress was not good and Ms W suffered incapacitating pain. Over the course of a few months Ms W experienced progressive stiffening of the ankle and was subsequently left with an equinus contracture. During the next few years she also developed a valgus deformity of her proximal tibia with some procurvatum. Her mobility deteriorated. The cosmetic appearance of her leg, although longer, was no better and overall her clinical condition was worse than before the operation. Eventually Ms W made a claim against Mr A. The experts involved thought it was difficult to decide how much of her subsequent problems were due to the surgery and poor quality of follow-up, or because of post-polio syndrome. However, due to lack of adequate medical notes, to demonstrate adequate warning of risks, the case could not be defended and was settled for a substantial sum.

Patients can often take away unrealistic expectations from what they see or read about in the media, and increasingly in social media. In these circumstances it is even more important to explore expectations about realistic outcomes, take proper consent and document appropriately. Remember good notes at all stages are the cornerstone of your defence. It is important that the patient fully appreciates all that is involved, not just in the surgery but in the follow-up. This can sometimes influence the final outcome as much as the operation itself. This case highlights the importance of a robust consent process when using innovative techniques. Limb lengthening surgery is highly specialised and complex. There are numerous recognised complications and these must be made clear to the patient. It can sometimes take more than one discussion before the patient is able to make a fully-informed decision to proceed with surgery. It is important to make timely decisions. MPS’s workshop Mastering Shared Decision Making is available via the MPS website.
Fifty-five-year-old Mr R had a history of hypertension for which he was taking an ACE inhibitor. He attended his GP, Dr S, with intermittent tightening of the chest and a sense of breathlessness. He did not have any symptoms of nausea or pins and needles. Mr R felt that he was suffering panic attacks, especially as he had recently been made redundant and was experiencing financial difficulties. On examination, Mr R's blood pressure was found to be high and Dr S attributed these symptoms to anxiety. However, he arranged an ECG and routine blood tests and asked Mr R to return to discuss the results.

When the results were available, Dr S considered the ECG for any abnormalities of rate, rhythm or appearance, and looked for changes suggestive of myocardial ischaemia or infarction. He felt that the ECG was essentially normal, aside from mild tachycardia, and did not see any gross abnormality requiring emergency admission. Two days later, Mr R attended the surgery as an emergency, complaining of chest pain, shortness of breath and nausea over the weekend. Dr S saw him before surgery began in the morning and arranged for emergency admission to hospital. The ECG and blood test results were sent along with a handwritten referral letter. Upon admission to hospital, Mr R clinically deteriorated and CPR was given; however, Mr R died within an hour of admission. The postmortem found that Mr R had a large saddle embolus in the pulmonary artery causing complete obstruction of the lumen. The left popliteal vein showed residual deep venous thrombosis and that this was the likely source of the fatal embolism.

Mr R’s widow made a claim against Dr S. Expert opinion criticised Dr S for his initial diagnosis of anxiety, his failure to consider that Mr R’s symptoms were potentially life-threatening and for failing to note that the ECG showed right bundle branch block and right axis deviation compatible with pulmonary embolism. Mr R should have been referred to hospital when he initially presented with chest discomfort, where a cardiologist would have diagnosed him and Mr R would have survived. The claim was settled for a moderate sum.

LEARNING POINTS

- Mr R had a number of risk factors for cardiovascular disease, including his age, high blood pressure and other symptoms that could possibly relate to circulatory problems. In any patient with chest discomfort you need to rule out serious cardiopulmonary causes with a careful history, examination and ongoing referral if warranted.
- You should refer a patient for further assessment if an ECG is abnormal if they have risk factors for cardiovascular disease. Mr R should have been admitted to hospital to exclude an MI, even if Dr S was unsure of the diagnosis, because of his risk factors for cardiovascular disease.
- Be aware of non-cardiac causes of chest pain. In this case, the history, in combination with tachycardia, pointed towards pulmonary embolism. However, the doctor only excluded a cardiac cause without considering embolism.
- Anxiety symptoms can be very similar to symptoms of more sinister pathologies. When assessing someone with a history of or new presentation with anxiety symptoms, consider risk factors for cardiopulmonary disease when taking the history, examining and arranging follow-up tests.
Mr Y was a 21-year-old unemployed man who lived with his mother. He was a heroin addict and in the last few months, he had started injecting into his groin. Each day he was buying heroin and cocaine and had recently served a prison sentence for burglary to fund his habit. Mr Y was well-known at the practice as he had attended since his childhood. The practice had supported him and his mother with some behavioural problems at school and with issues around domestic violence before his father had left home. His mother had schizophrenia and was also a regular attender at the practice.

Both Mr Y and his mother had been a case for discussion as practice staff were finding them increasingly difficult to manage. Lately, they had both been regularly missing appointments and were rude to staff. Mr Y frequently requested appointments for minor ailments, such as lower back pain and colds, yet upon attending he asked for methadone or pethidine. His behaviour was rather manipulative and consultations were often challenging.

During one month, Mr Y attended several times complaining of back pain and feeling unwell with flu-like symptoms. Dr S and his partners saw him and documented their history and examination. It was recorded that he was suffering with severe back pain and feeling “hot and cold”. His temperature had been recorded as 38.9 degrees. Notes also stated that he had symptoms of severe constipation and difficulty passing urine.

A blood test had been arranged, which showed a significantly raised ESR and white cell count – the results were not acted upon.

Mr Y began to feel worse and was struggling to get out of bed due to the severity of his back pain. His mother attended the surgery on his son’s behalf to ask for a home visit, but one of the receptionists refused the request and asked the patient to attend surgery. She mentioned later that Dr S had said previously that “he couldn’t do any more for the family” and that she was trying to help.

The next day Mr Y felt very weak. He tried to get out of bed and collapsed. His mother called an ambulance and he was rushed to hospital. He was diagnosed with endocarditis and discitis. Despite intravenous antibiotics he died of overwhelming sepsis. His mother was devastated and made a claim against Dr S’s surgery. The case could not be defended and was settled for a moderate amount.

LEARNING POINTS

- Frequent attenders can and do have serious illnesses; doctors must not let an element of “crying wolf” blind their judgment. It is important to keep this awareness and objectivity when seeing patients.
- When investigations are requested it is important to have a system in place to ensure they are acted upon if necessary.
- Effective triage is an integral part of general practice and is better based on clinical need rather than catering to the most persuasive or demanding patients. An effective triage system could help direct patients to the most appropriate appointment at the most appropriate time, and identify patients who have an immediate medical need.
- The management of patients who are drug users raises issues that may need discussing within the practice to offer better care. For example, there should be an awareness of the guidelines to support patients with addiction including where and how to refer patients for support and/or detoxification, and offer “shared care” for the management of drug misuse.

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We have published the letter we received a large number of correspondence regarding last issue’s case, “Slipping through the cracks”. We have published the letter below as an example of the concerns raised, which were similar across all the letters we received. MPS’s response is also below.

Response

Many thanks for your recent correspondence about the case report, “Slipping through the cracks”. We have, perhaps unsurprisingly, received many letters and emails from members working in different specialties and different countries, expressing similar views: Why was the case settled? What more could the GP have done? Where does the patient’s responsibility lie?

On reviewing the claim, there are a number of differences between the facts of that case and the facts described in Casebook, such that the material omissions (failure to adequately monitor or manage significant hypertension in presence of multiple cardiovascular risk factors) which led to expert criticism in the case, do not appear in the account given in Casebook. I offer my personal apology for this – we do change details of cases prior to publication so that anonymity of the parties is preserved, but on this occasion the changes severely compromised the credibility of the case and this was not picked up by our editorial process. Indeed, it is your MPS Editor-in-Chief who has ‘slipped through the cracks’ on this occasion. And we have some learning points to ensure that this does not happen again.

I am heartened to some extent that so many of you have taken the trouble to put us right, but am extremely sorry if the report caused unnecessary anxiety.

Dr Stephanie Bowm, Editor-in-chief

A pain in the leg

I cannot disagree more strongly with your conclusion that Dr C had done everything she could and should have done. Clinical examination along with “Homan’s sign” should be consigned to the clinical dustbin. How many more people will die from undiagnosed DVT causing a massive PE through a clear lack of understanding? You should be shouting the message loud and clear that a normal clinical examination has absolutely no predictive value in excluding a DVT whatsoever. It is useless!

Even a Wells score of 0, which it would have been in this lady, places her in the “Low risk” group. This is not the same as no risk.

What Dr C should have done is a d-dimer. Forget her fabulous documentation. There is no clinical finding that excludes a DVT. That you defended the claim successfully is a travesty. A life was lost. A positive result would have led to a Doppler USS, which may just have saved her life.

Dr S J Wallace, UK

Nasogastric tube errors – 1

The article relating to errors surrounding nasogastric tube placement (Casebook 20 (3)) raised several important issues pertinent to both junior doctors and also radiology performance and interpretation. The article mentions specifically the timing of tube placement and imaging – as far as possible this should be done in working hours when senior doctors and radiologists are available to assist with image evaluation.

Junior doctors will need training in chest radiograph interpretation, but often these radiographs are done in sick patients and image quality is poor, making assessment difficult even for more experienced doctors. Junior doctors must be able to appreciate when they need help and should ask for senior advice if there is any doubt; all decisions and consultations must be clearly documented in the patient record.

The article covers also in some detail how to approach a chest radiograph following tube placement – it does not mention some crucial points, namely that before any attempt at image interpretation is made the reviewing doctor must check that the film is of the correct patient done at the correct time and date. This is essential, especially on ITU for example, where a patient may have multiple chest radiographs in a day – errors are still made when the incorrect film is reviewed and cleared.

There is also the issue, alluded to in the article, of getting radiographs formally reported by a radiologist, ideally on the same day for inpatient work. This is a problem area in many trusts, with often long delays in getting inpatient films reported, or in some cases not reporting them.
Primary postoperative care

There’s a theme running through increasing numbers of the recent medical incidents reported in Casebook that does not entirely seem to have been picked up by your case report writers and I believe is worthy of discussion. This revolves around the increasing pressure on hospital doctors and medical teams to discharge patients as rapidly as possible back to primary care.

A case in point was in the article “A normal appendix” in the May 2012 issue, where a patient subsequently found to have a Meckel’s diverticulum as the source of problems was discharged one day after appendectomy in such apparent haste that neither the consultant nor the trainee saw him, and the article also makes clear that no follow-up appointment was offered. Subsequently the patient made numerous visits to his GP and to hospital Emergency Departments before the real reason for the problem was identified.

This pressure on hospital doctors to ‘get rid’ of their patients back to the community is encapsulated in a set of rules known as NTFRU (new to follow-up ratios) and is being applied ever more ruthlessly across the country. A figure for the average ideal number of times a patient should be seen by a certain specialty (and not by pathology) is devised without published evidence and imposed upon specialty departments. Often the ratio is well under one to two. Lead clinicians whose departments do not stick to the figures are called in by administrators (as I have found myself) and pressured to comply.

Clearly, because hospital care is seen (often wrongly) as expensive, the stimulus for this is cost-savings. However, it should fail to us as medical professionals to point out the very considerable dangers and indeed false economies. Firstly there is often no continuity of care because GPs understandably often feel unable or unwilling to deal with the nuances of postoperative care. Patients such as that in “A normal appendix” suffer needless delays and sometimes injury in reaching the real diagnosis.

Finally, over a longer period there’s a massive loss of skill, experience and learning because surgery does not end at the door of the operating theatre or ward. It ends when the specialist discharges the patient from the follow-up clinic cured of his/her symptoms, and it’s often during that follow-up that as a surgeon one realises one has missed something or perhaps done something less well than one might have. The changes now being forced away from us by NTFRU reduce the experience and excellence of doctors, nursing and clinical support staff. The problem applies equally in public and private practice where insurers are starting to apply the same pressures. Professional organisations and indeed our indemnity providers need to support doctors in dealing with this.

Dr David Howlett, UK

Nasogastric tube errors – 2

We write in reference to the special feature article regarding nasogastric (NG) tube errors.

The guidance that you quote from the NPSA is very difficult to implement in practice in many clinical circumstances. There are unintended consequences that expose patients to risks from repeated doses of radiation with multiple X-rays and failure of delivery of nutrition or medication for long periods; as well as increasing healthcare costs. The evidence quoted in the NPSA guidance is weak and focuses on small numbers of serious adverse events, while ignoring very large denominator numbers of tens of thousands of patients who receive NG feed to put numbers into perspective.

While we were pleased to see an article highlighting this important and preventable cause of morbidity and mortality in healthcare, there was a vital omission in the discussion: the implications of acid suppressing drugs for confirmation of NG tube position. Many critical incidents occurring with misplaced NG feeding tubes occur in ventilated critically ill patients. This group of patients frequently receive prophylaxis against stress ulceration with either an H2 antagonist or proton pump inhibitor, in line with national and international standards of care for ventilated patients.

The administration of these drugs frequently results in gastric aspiration that is above pH 5.5, necessitating a chest X-ray as proof of correct NG placement. The bullet point relating to repeat checks states that NG tubes “can be dislodged so they should be checked every time they are used, by aspirating and confirming a low pH, and only X-raying if this is not the case” – this needs further clarification. In a group with increased gastric pH this would mean a chest X-ray every time an NG drug is administered – possibly multiple times over the course of a day. We would suggest that
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will be receiving concurrent
GPs are well aware of how
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AVOIDING THE RISKS
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The suggestions in the article “Getting the best out of online reviews” by Neil Bacon surprised me since they are the exact opposite of what I’d advise. I’m not aware of “powerful benefits” of online reviews. What is possible is that anyone may write anything they like about a doctor. There is no peer editing, there is no restriction, the writer cannot be identified (they might not be who they say they are) and there is no sanction against a derogatory or even malicious review.
Dr Bacon says that reviews are the norm in other service sectors. There have been documented cases of damaging reviews written by rivals of commercial organisations, the writer never having partaken of the service on which they are commenting. The motive is plain: to put a competitor out of business. Tracking these people down requires cyber detective work and there is no guarantee of success. The derogatory information might even be passed through a server in another country so it becomes difficult to invoke UK law – which itself offers scant protection anyway.
Hoping that a site is “secure, robust and has proven systems to prevent abuse” is no more than wishful thinking. Nothing on the internet is that secure. How does a doctor “ensure” that a site is secure, anyway? How many of us would understand the security measures in place, let alone be allowed to know their exact nature and function?

The internet: target practice?
This letter refers to an article that was in our UK edition only. To read it, visit: www.medicalprotection.org/uk/casebook-september-2012/getting-the-best-out-of-online-reviews.

Information on one website quickly spreads and copies appear on others. Look at how social networks have become the new playground for school bullies. It just takes one disgruntled patient to ruin your reputation through the web – and you can’t stop it. The greatest difficulty is removing adverse comments. There is no enforcement to make sure this happens. Many websites have no direct means of contacting their operators, there’s no compulsion to reply to any email you might send them. Finally, what if you disagree with something an identifiable patient says about you? Any reply would be breach of confidence; it’s the same problem as when trying to handle adverse newspaper publicity.

There are various branches of engineering – civil, mechanical, electronic, etc. The new discipline of socially-appropriate engineering is now becoming recognised. Of any technical achievement, it asks not can we do it, but should we do it? Yes, you can hand out cards to encourage patients (or anyone) to publish comments about you on the internet. Should you do it? Of course not. You can stick your head over the parapet if you want, but when they start to shoot, you can’t stop them.
Dr Godfrey Manning, UK

for ventilated critically ill patients the wording should be changed from “every time they are used” to “if there is any suspicion of displacement”. This can be aided by ensuring that the cm marker at the nostril following insertion is clearly documented and checked every time the NG tube is used.
The guidance also has implications that extend far beyond critical care. There are many patients in community hospitals and rehabilitation units receiving NG feeding, who will be receiving concurrent acid suppressing drugs. There are large numbers of confused patients who repeatedly pull out NG feeding tubes and multiple x-rays on a daily basis and who are impossible to sustain. In many of these units there may not be direct access to x-ray facilities available. The guidance makes the maintenance of regular adequate enteral nutrition and medication administration impossible for large groups of patients, and should be revised. The major difficulty with that is that the NPSA was abolished last year and there is no mechanism for revision.
Dr Neil Young and Dr Brian Cook, UK

Skipping over the details
“Skipping over the details” (Casebook Vol 20(3), p14) raises an interesting point. It was a year from the first consultation to the next. At first sight this seems surprising; why ever did the patient not come back sooner; is the doctor really so responsible for the late presentation? After all, doctors can only ever offer reassurance that is relevant at the moment in time it is given, not that there will not be a problem later. GPs are well aware of how presentations may change over time; that a significant diagnosis may not be obvious at first presentation.

Indeed the observation of illness over time is an essential part of our trainee GPs’ learning experience.
Patients on the other hand seem to treat the reassurance as not anchored in time as it were, and treat it as if it could be considered as ongoing: “The doctor told me it was alright six months ago, so it’s ok now…” It seems that the lay belief is that all problems are obvious from first presentation. Perhaps patients also underestimate the time it was since they last consulted about the problem and thus falsely believe that the reassurance is more recent than it actually was. From our point of view it all seems so unfair.
While this might raise the possibility that patients could consult too soon and be given false reassurance before the problem becomes clearer, the issue for us is to communicate the need to reattend if the problem gets worse, or other symptoms develop. So: are we approachable? Can we somehow give permission in advance to come back as well as showing a personal interest? A phrase offered to our trainees to adapt is something along the lines of: “If this thing misbehaves itself in any way I want to know about it…” Trainee GPs would be asked to record a contingency plan (in this case an ultrasound scan) to give some idea of what is expected. Another possible technique is to inject some deliberate uncertainty such as “I think that’s OK, but you must let me know if…”
Dr Paul Vincent, UK
The Creative Destruction of Medicine by Eric Topol
Reviewed by Dr Muiris Houston, medical journalist and health analyst

Not that long ago a discussion about “digital medicine” could only be construed as a reference to rectal examination. Such has been the pace of technological change and of the digital revolution, that an updated form of digital medicine is now unquestioningly seen as part of modern medicine’s cutting edge.

In his book, The Creative Destruction of Medicine: How the Digital Revolution will Create Better Health Care, Eric Topol, chief academic officer for Scripps Health, a non-profit healthcare system based in San Diego, argues that the digital revolution can democratise medical systems in a groundbreaking way. The creative destruction in the book’s title comes from Austrian economist Joseph Schumpter, who popularised the term “creative destruction” to denote transformation that accompanies radical innovation.

Topol boldly predicts the end of ‘one-size-fits-all’ medicine; instead patients can look forward to personalised and customised solutions for their health problems. It is almost Nirvana-like: as we collect ever more complex medical data about ourselves we can look forward to more personalised care at the point of delivery.

Informed consumers will be in the driving seat, controlling their own healthcare based on genomic information and real-time data obtained wirelessly through nanosensors.

Social networking will play a major role as ever-widening online health communities provide us with peers whom we never meet but who become crucial guides as we come to terms with our illness.

Topol really is convincing on the technological aspects of this coming revolution. But readers may have greater difficulty envisaging the consultation of the future. What will happen in the valuable crucible of the doctor – patient interaction?

In the years ahead Topol says he expects up to 70% of office/surgery visits will become redundant, “replaced by remote monitoring, digital health records and virtual house calls”. But there is no convincing narrative to back this up, leading this reviewer wanting a follow-up volume in order to be entirely convinced that Topol’s transformation can work in the trenches of frontline medicine.

Thinking Fast, and Slow, by Daniel Kahneman
Reviewed by Dr Mareeni Raymond, GP in London

Daniel Kahneman’s book was recommended to me by my GP study group, my colleague telling me it was a must-read for any doctor. The book has been a bestseller since it was published in 2011 and having just read it I can see why: I couldn’t put it down.

Kahneman is an Israeli American psychologist who has published some of the most well known and important papers on the subject of behavioural psychology. This book covers some of his and his colleagues’ most notable ideas, experiments and theories about decision-making, behaviour and judgment.

Although his book may at first glance appear to be aimed at business people and economists it gradually becomes obvious that absolutely anyone could relate to the book’s principal ideas, and could benefit from an understanding of the psychological theories described. As doctors we need to make quick decisions about patients as well as the interpretation of clinical information and statistics. We expect our decisions to be based on experience, intuition and knowledge. However the conclusions each person draws are different and this book clearly describes the possible reasons why.

Our brains are tainted by presumptions and are subconsciously influenced by what we are exposed to in our daily lives. This is partly about cognitive bias, which Kahneman describes in the first part of this book.

If you are a person who questions what is happening around you, and is interested in understanding your own thought processes with a view to improving judgment, you will be enlightened. Take for example the effect of cognitive bias: it can lead to mistakes, inaccurate judgments, irrational behaviour and illogical conclusions. Perhaps we know that we are influenced by what is around us – that isn’t a new idea – but what is so powerful about this book is that it points out totally unexpected and unpredictable influences on our state of mind. When a patient walks into a room there are hundreds of reasons why you may come to a conclusion – by understanding those reasons perhaps you can check yourself – that is, think slow, rather than fast, and make better judgments.

The reader may be put off by the potential of complex ‘science bits’ and long words – this is not something to be worried about. It is a bestseller because it is accessible, written in an informal way, each chapter peppered with example questions, scenarios, and details of experiments that clarify the arguments made for each of the theories. Today our minds are heavily bombarded by mass media and marketing, and Kahneman’s book also helps us unravel the decisions we make outside the workplace. After reading the book perhaps having an understanding of these shortcomings will make us question our decision-making, our behavioural responses and our confidence in judgments, but hopefully in a positive way.
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